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Should Internal Displacement Mean Deprivation of Healthcare for Women and Children in Nigeria?

By Ijeoma Igwe¹, Prince Agwu², Uzoma Odera Okoye³, Nkechi Onyeneho⁴

Abstract

Nigeria accounts for a high percentage of globally displaced persons, most of whom are women and children. Health conditions of women and children in camps of Internally Displaced Persons (IDPs) have been topical, and so much of concern is on their access to quality healthcare services in the camps. The study adopts Key Informant Interviews (KIIs) in capturing responses of 12 officials from the Kuje and Fariya IDP Camps in Abuja and Maiduguri respectively. It also adopted the use of thematic analysis in analyzing the data. Findings showed that healthcare facilities exist in these camps, despite occurrences indicating poor health conditions of the IDPs. The study concluded that health inequities persist in both camps, and that the challenges facing the available health facilities should be adequately addressed. Among the challenges were corruption, poor staffing, poor environmental conditions, bureaucratic bottlenecks, and absence of adequate and well-trained social service professionals.

Keywords: Conflict, Maternal health, Child health, Healthcare access, Internally Displaced Persons, Universal Health Coverage

Introduction

Internally Displaced Persons (IDPs) are those in search for survival within a particular sovereign territory owing to a forceful drive away from their natural habitat or residence by conflicts or natural disasters (Oduwale & Fadeyi, 2013; Odu, 2017). The globe is currently experiencing increasing cases of IDPs (Internal Displacement Monitoring Centre [IDMC] 2017a; Norwegian Refugee Council, 2015; Odu, 2017). IDMC (2017a) puts global IDPs as at the end of

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2016 at 40.3 million people, with Nigeria, Syria, and Iraq accounting for a larger share of the figure against all other countries. IDMC (2017b) reports that in Nigeria 2,598,000 persons were displaced between 2016/2017 as a result of the Boko Haram insurgency and herdsman-farmers' clashes, while 80,000 joined the ranks of IDPs following natural disasters.

Of all IDPs in Nigeria, only 10% reside in the ~150 camps scattered across the country (IDMC, 2017a) which provide temporal residence for them until their residences are free from conflicts and disasters. However, of pertinent concern is the care for those who reside in the camps (Amnesty International, 2018; Eweka & Olusegun, 2016; Jalili & Olanrewaju, 2016; UNHCR, 2016). Given conditions obtainable in the camps, it is reported to be a high-risk environment, where a mix of several factors affects the health and wellbeing of the residents (IDMC, 2017a; Owoaje et al, 2016).

Camps for IDPs are regarded as informal settlements (African Union Commission [AUC], 2015). Informal settlements are places where people dwell temporarily and cannot lay legal claims to ownership. Most informal settlements suffer health inequities (UN Habitat, 2015). It is usually worse in low- and middle-income countries, owing to how often they are neglected by their governments. A first step to addressing this inequity is the provision of quality, accessible, and affordable healthcare services.

Access to healthcare is defined as one's ability to obtain and appropriately use good quality health technologies and consumables as and when needed for good health (Ensor & Cooper, 2004). This remains a challenge for IDPs who face the prevalence of certain health conditions including trauma, malnutrition and starvation, diarrhoea, acute respiratory infections, fever, malaria, measles, pregnancy-related complications, depression, and sexually transmitted diseases (Akuto, 2017; Geranda et al, 2015; Owoaje et al, 2016). The 2016 NOI-Polls reveal that the myriad of illnesses faced by IDPs is connected to lack of access to quality foods, regular meals, and healthcare. In a survey they conducted in IDP camps across Abuja, 85%, 78%, and 69% lacked access to good meals, potable water, and quality healthcare respectively. While this is not farfetched from what is obtainable in the North-East region of Nigeria, Human Rights Watch (2016) added that the women in the IDP camps are often at sexual risk, which equally contributes to poor health conditions and women's mortality cases.

We found that most studies (Odu, 2017; Jalili & Olanrewaju, 2016; Owoaje, 2016; Oduwale & Fadeyi, 2013; Akuto, 2017; UNICEF, 2017) using theoretical and quantitative approaches underscored the consequences of poor and inadequate healthcare services on mortality experiences in IDP camps. Some other studies considered the health and psychosocial conditions of IDPs not within a camp setting (Olanrewaju et al, 2019). Our study takes a departure from what is obtainable across literature, because of its qualitative insights into current levels of access to healthcare services in IDP camps and its focus on women and children. It is hoped that findings will impact Nigeria's policy on IDPs, as well as efforts made by donor agencies and external bodies in improving health conditions of the internally displaced population in camps.

Theoretical Framework

This study is anchored on the structural theory of health inequality. The theory is rooted in the works of Black et al (1980), Acheson (1998), and Marmot et al (2010). It fundamentally asserts that differences in socioeconomic circumstances of social groups during life-course affect their health outcomes (Krieger, 2001; McCartney et al, 2013). Displacement can be considered a part of the life-course, although it is usually unplanned. Those who are displaced form a social group

that is often characterized by poor living conditions. It is worse for this group of persons in climes like Nigeria, where social care and social security are usually non-existent. Thus, becoming a part of the displaced population in Nigeria naturally deprives people of the basic necessities of life, including healthcare. This is the reason poor health conditions of IDPs could be best described as health inequality or inequity, since it could be peculiar to the situation on camp (McCartney et al, 2013). Therefore, it becomes the responsibility of good governance to ensure that displacement as a life-course and the consequences in terms of poor socioeconomic conditions do not affect access to quality and affordable healthcare by the displaced population. This is a major pursuit of the AU 2063 Agenda, as well as the 2030 Universal Health Coverage. Hence, this paper puts forward health inequalities or inequities obtainable in the camps of IDPs as a result of blocked access to healthcare.

Materials and Methods

Study Area

Kuje and Fariya IDP camps are located in Abuja and Maiduguri. Both camps host IDPs running in thousands (News Agency of Nigeria, 2018). Health services for both camps are not institutional but made available intermittently, mostly by NGOs, national agencies, and international humanitarian organizations (NOI-Polls, 2016). Absence of a well-institutionalized healthcare system in the camps buttresses the need to investigate access to healthcare services.

Sampling Procedure

Given the security of IDP camps in Nigeria which often limits the access of private researchers to the IDPs, we resorted to the use of purposive and snowball sampling techniques to secure an audience with 12 camp officials. We drew 6 from Kuje camp and another 6 from Fariya camp. Adopting the snowballing technique, we asked respondents to assist us with the phone-contacts of their colleagues until we were able to arrive at twelve of them.

Data Collection

Data were collected through telephone interviews with key informants within the period of March and April 2018. Three of the researchers made phone-calls with smartphones that had the feature of “call recording”. The phone-calls lasted for an estimate of 45 minutes. For convenience reasons, the interviewees selected the exact time they were ready to be interviewed. The researchers collectively designed the KII guide for the purpose of uniformity in the conduct of the interviews across different times. To add rigour, the KII guide was vetted by 2 scholars in migration studies whose suggestions were taken on board for the improvement of the guide. Further, we sought ethical approval through the health research ethics committee of the University of Nigeria Teaching Hospital. Again, on ethics, IDP camp officials were requested to offer oral and written consent prior to the conduction of the interviews. Oral consent was done through a phone-call, while the written consent form was sent to their various email addresses, which they filled and returned before commencement of each interview.

Data Analysis

Data were analyzed thematically after producing transcripts for each audio record. With guide from the research questions, transcribed responses were placed in thematic categories to include (1) The extent to which the health of the women and children were endangered in IDP

camps (2) The common health problems faced by the women and children in the camps (3) Availability of health services in the camps (4) Barriers experienced by women and children in accessing healthcare services in the camps.

Results

Demographic Features of Participants

12 IDP camp officials were the key informants for the study. They were mainly women between ages 30 and 45 years. See the sociodemographic features of the respondents below:

Table 1: Demographic Information on Respondents

Code	Organization	Age	Gender	Religion	Educational level	Camp
001	National Emergency Management Agency [NEMA]	44	Female	Christianity	MBBS	Kuje
002	NEMA	36	Female	Christianity	B.Sc. Nursing	Kuje
003	FCT Emergency Management Agency [FEMA]	42	Male	Islam	M.Sc. Sociology	Kuje
004	FEMA	31	Female	Islam	MBBS	Kuje
005	Save the Children	25	Female	Christianity	M.Sc. Social Work	Kuje
006	Save the Children	28	Female	Christianity	M.D.	Kuje
007	UNICEF	45	Male	Islam	M.D	Fariya
008	NEMA	26	Female	Christianity	B.Sc. Social Work	Fariya
009	NEMA	30	Female	Christianity	M.Sc. Sociology	Fariya
010	Save the Children	29	Female	Christianity	M.Sc. Public Health	Fariya
011	Save the Children	27	Male	Christianity	B.Sc. Nursing	Fariya
012	Save the Children	38	Female	Islam	MBBS	Fariya

State of Maternal and Child Health in the Camps

Concerns were raised about the health status of women and children, with participants equally reporting mortality cases. It was linked to a dearth of adequate health workforce and a weak healthcare setting in the camps. A doctor said:

.... Well, the state of maternal and child health in the camp is very poor. They don't get proper medical care. The health workforce is understaffed and health facility is very poor. Generally, their health status is poor [...] Death happens often in the camp and women and children are the most affected [NEMA, 001, Doctor].

From Fariya Camp, a nurse talked about poor access to healthcare which she attributed to the population increase in the camps:

They have serious health problems here. It is very bad because they don't have a proper health facility in the camp. They are really suffering here and this I believe is because the population in the camp is much. Getting adequate healthcare here is really difficult [Save the Children, NGO, 011, Nurse].

A nurse also spoke from a lens of poor nutrition and hygienic conditions. She said:

The women and children suffer from poor health conditions. The major cause of health problems apart from poor medical care is hunger and poor hygiene. Women and children are at risk of disease outbreaks in the camps because they do not feed well nor live healthily [NEMA, 002, nurse].

Common Health Problems among Women and Children

A number of health problems were mentioned, though with slight variation across the study sites. Malaria, typhoid, and cholera featured predominantly in both camps as a result of the poor hygienic conditions of the environments, while meningitis featured mainly in Maiduguri. Generally, poor nutrition accounted for the prevalence of these diseases, and the dearth of quality amenities made matters worse. Below are samples of quotes that illustrate these findings:

Malaria is very rampant in the camp. Typhoid is also another sickness that ravages people in the camp. For children, the major health challenge they have is diarrhoea and malaria [FEMA, 004, Doctor].

For mothers, especially pregnant women, the common health problem among them is malaria. You know the camp environment is very dirty, sanitation is poor, and malnutrition is the order. No water facility which they usually blame on lack of gas to provide water in the camp. Generally, the place is malfunctioning [Save the Children, 006, Doctor].

There is a high risk of epidemic in the camps. Other illnesses are cholera, meningitis, and malaria. I think hunger is another major health challenge they have in the camps. For me, malnutrition exposes them to all these illnesses [Save the Children, 010, Public Health Expert].

The children in the camp usually suffer from cholera. The reason why this is the common health problem is because they don't have good toilet systems. The place is very dirty, no clean water for them to drink. Hygiene is just too poor [FEMA, 003, Sociologist].

To curb the spate of these illnesses, they need to not only make healthcare available but address the debilitating environment conditions in these camps.

Availability of Maternal and Child Healthcare Services in the Camps

All respondents indicated the availability of clinics in the camps. However, most of the respondents held the view that the clinics were insufficient to contain the population in the camps, or stated that they are poorly managed. To begin, one of the officials said:

Yes, we have mobile clinics here, but I can't really say that the clinics are enough. The population in this camp is much and most times you find a lot of people clustered at the clinics. So, I think they should be provided with more clinics to enable the women and children to access healthcare more effectively [NEMA, 008, Social Worker].

Confirming the assertion above, another IDP official had this to say:

I know they have tents where they attend to sick people in the camps. If you visit these camps, you will see how clustered these tents are. I don't think they find it easy using the available healthcare services [UNICEF, 007, Doctor].

Another official commented on the absenteeism of health workers which stalls the efficacy of the available healthcare services:

There is no serious health care service going on here because they are not always available. What they do is a day off and a day on. [FEMA, 003, Sociologist].

In corroboration, a NEMA official said:

From my experience, healthcare services are not readily available in the camp. Most times it will take so much phone-calling to get the health personnel to come to the camp which causes long delays [NEMA, 009, Sociologist]

Lastly, a Sociologist from the Kuje Camp made a case for insurance. He emphasized how IDPs are denied being treated because they lack money to pay their bills, especially in cases when they are referred to facilities outside the camps:

There is no good clinic in the camp. What happens is that most times they refer the cases that they cannot handle to a bigger hospital in Abuja town. The bad thing there is that once the nurses or the hospital management recognizes the patient as an IDP, they will not agree to attend to the patient because they know he or she cannot pay for their services. There is no proper health insurance system for them [FEMA, 003, Sociologist].

Barriers in Accessing Healthcare Services for Women and Children in IDP Camps

Among the mentioned barriers included insufficiency and poor management of clinics in the camps, dearth of medical consumables, inefficient healthcare staff, sexual harassment, poverty, etc. A Public Health expert gave her thoughts:

... A major problem they have is a lack of dedication on the part of the health workers. There is no sense of dedication and no passion for the job they are being paid for. Again, drugs are not always available because they are usually diverted [Save the Children, 010, Public Health Expert].

Adding to the challenges as highlighted above, is the issue of women being overpowered by men in the scramble for limited health resources. A nurse narrated thus:

From what I have seen in the camps, the major problem they have in accessing healthcare services is the availability of drugs. Since there are a lot of people in the camp, they also need plenty of drugs to go round. Another challenge they have is

limited clinics. They do not have enough clinics to cater for the population in the camp. Most times the men overpower these women. It even happens in food sharing. Men hijack the food and try to reserve some for their girlfriends [NEMA, 002].

Sexual harassment was said to impede the freedom of women from accessing available healthcare services. It could be that moving about the camp opens them up to sexual advances, thus, restricted movement becomes a form of security:

The women and girls have a major problem that prevents them from accessing these services. Most of these camp officials harass them sexually. For me, I think that is a more serious problem as they always complain about this. It affects their freedom [FEMA, 004, Doctor].

Economic barriers are featured as well. Most IDPs were said to not have enough money to pay for medical consumables and services, especially in cases when they are referred to medical facilities outside the camps. The UNICEF official narrated:

We have many problems here. IDPs with severe health cases do not have money to go to the hospital. One of them whose child suffers sickle cell illness needed medical attention but could not get it. We are trying to see how we can help. Other times, they would be referred to go buy some expensive drugs outside here, and they cannot. No insurance for them [UNICEF, 007, Doctor].

Weak health workforce in terms of quantity and quality, as well as poor nutrition were also mentioned as the barriers. IDPs need food to sustain their health. Even if quality healthcare services are available, when the meals are poor, there are high chances of the IDPs perpetually falling sick. A doctor commented:

The clinics are not really enough for the IDPs. More health personnel are also needed in the camps. Even though they have a lot of volunteer workers in the camps, how competent are they? Also, because these women and children do not eat good food, they are bound to always falling ill [Save the Children, 012, Doctor].

The bureaucracies at the camps made it difficult for medical consumables to reach the IDPs as quickly as they should. Camp officials wished for speedier processes:

One barrier to health services in the camp is security. It is difficult to supply drugs and medical consumables to the camp. You need to procure it and clear with the military and sometimes it takes weeks before they arrange for an escort to lead you to the camp. So, the delay in logistics is a major factor in health care delivery [UNICEF, 007, Doctor].

Lastly, some officials lamented the issue of corruption. One of them said:

Another major problem is corruption. It manifests in stealing, diversion...Government and NGOs are trying and if the IDPs can have access to all the items that are supposed to come to the camp, they will have a more meaningful life. For instance, if they send a truckload of provision to the camp, the person in charge and others will start stealing those things. It happens to virtually everything sent to the camp. They steal food, clothing, drugs, and all sorts of other things [FEMA, 003].

Discussion

The study investigated access to healthcare services by women and children in camps of IDPs. Responses were given by 12 Camp Officials from the Kuje and Fariya camps in Abuja and Maiduguri respectively. Generally, the study revealed that the camp residents grapple with poor health conditions. However, women and children were found to be most affected, with recorded incidences of maternal and child mortality. Same finding is corroborated in other studies (Eweka & Olusegun, 2016; Odu, 2017; Olowolagba, 2018; UNICEF, 2016; UNICEF, 2017).

Our study reveals that health facilities are available in camps, but are insufficient, poorly managed, and understaffed. We found this to be a very crucial reason for the poor health experiences of women and children in these camps, and even more, the frequent occurrence of mortality cases. Beyond the several reasons why the availability of healthcare services in the camps is yet to translate into improved health outcomes for the camp residents, is that available healthcare services do not match the population present in the camps. Thus, inasmuch as the participants were of the opinion to scale up the quality of the healthcare facilities in the camps, they equally emphasized the need to increase the number of facilities or employ more healthcare workforce. The idea is not just to make healthcare available but to reduce delays and blocked access the IDPs encounter while seeking healthcare (Eweka & Olusegun, 2016; Olanrewaju, Omotoso & Alabi, 2018a; Olanrewaju, Omotoso & Alabi, 2018b).

Further, we investigated the common illnesses faced by women and children in these camps. We found out that malaria and cholera took the lead. This was attributed to the unhygienic environments in camps which breed mosquitoes and the poor toilet conditions. Meningitis was found to occur just in Fariya Camp, Maiduguri, which we infer could be a result of the extreme weather conditions in the state that cause excessive heat. Given the prevalence of malaria in the camps, it is expected that mortality cases will be obtainable, owing to reports that indicate malaria as a major cause of childhood mortality in Africa (FMOH, 2012; NPC and ICF Macro, 2014). Therefore, improved health outcomes by the provision of health services must be complemented by decent environments.

Absenteeism of healthcare staff was also highlighted as a barrier to accessing health services. This affected the provision of healthcare to the IDPs at the times they would want it or led to longer waiting periods. It also led to the IDPs clustering the clinic in attempt to maximize the opportunity of the rare presence of the health workers. The impacts of absenteeism of healthcare staff on the achievement of Universal Health Coverage in low and middle-income countries are discussed in some studies (Onwujekwe et al, 2018; Onwujekwe et al, 2019). During the times when the health facilities are clustered, the men tend to overpower the women because the women are considered weaker. In all, if health workers do not come to work, then it will be difficult to make available healthcare services match the population demand in these camps. We

discovered that the issue of absenteeism of healthcare staff working in healthcare facilities in IDPs' camps is an area that calls for more investigation.

Our data also show that health facilities in the camps are poorly equipped in terms of medical consumables and tools. There is a similar finding in NOI-Polls (2016). Owing to this failure, women and children who suffer severe illnesses are taken out of the camps for medical attention. Facilities outside these camps reportedly refused treating the IDPs because they might find it difficult to pay for the services. This was said to be recurring and appears a leading cause of mortality experiences for the women and children in the camps. It is in this regard that officials lamented the absence of health insurance for IDPs that should otherwise guarantee them quality healthcare at any level that supersedes healthcare services offered in the camps.

Amidst the poor health conditions of the IDPs, the key informants mentioned that the government and humanitarian agencies were making some efforts toward the welfare of the IDPs. This contradicts findings from NOI-Polls (2016), Olanrewaju et al (2018b), and Kim et al (2007). However, they were worried about some internal sharp practices involving camp officials such as diversion and theft of medical consumables and relief items (Eweka & Olusegun, 2016; Olanrewaju et al, 2018b). These sharp practices cannot be unconnected with the experiences of the IDPs as regards poor health conditions and feeding. Given the limited consumables and relief items that eventually come into camps, the displaced persons tend to struggle to have a share. In the process of struggling, the men dominate the women.

Given this occurrence of sharp practices, there is a need to pay attention to horizontal behaviours in the management of the camps. As we found in this study, sharp practices were reportedly much obtainable within the institutions of these camps. For instance, medical consumables and relief items are stolen by camp officials, health workers are absent at duty posts, camp officials and residents indulge sexual harassments, among others. This in no way exonerates corruption happening at vertical levels, which could even encourage deviant behaviours at horizontal levels. Thus, we recommend an all-encompassing approach to anti-corruption if health equity must be entrenched in the IDPs' camps. The efficacy of a combination of horizontal and vertical approaches in combatting corruption is discussed in Onwujekwe et al (2020). Therefore, it is recommended that measures are put in place for whistleblowing, rewarding the whistleblowers, and stringent sanctions on fraudulent persons to strengthen measures against corruption in the IDPs' camps.

Furthermore, sexual exploitation of women puts them in severe psychosocial conditions, where they barely want to move about, which consequently restricts them from accessing health facilities. It is therefore important that psychosocial professionals like social workers and psychologists are adequately deployed to these camps. These professionals can provide psychosocial therapy and, very importantly, protect the rights of these women from abusers through initiating sensitization and advocacy activities, whistleblowing, investigations and prosecutions, and social actions at necessary times (Akuto, 2017; Getanda et al, 2015). Lastly, the informants lamented the bureaucracies encountered in delivering medical consumables and food supplies to camps. This is because it delays the time these important items should get to the IDPs. It slows down the delivery of healthcare services and could also affect the morale of healthcare staff. The need to make this process swift is considered very vital to good governance and having IDPs secure speedier access to healthcare services made available to them (Olanrewaju et al, 2018b).

Conclusion and Recommendation

Our study contributes to the body of literature on IDPs in Nigeria by offering insights into the availability and accessibility of healthcare services by women and children residing in the IDPs' camps. Data came from health experts who had affiliations with working in the camps. Overall, we observed that poor health conditions were prevalent in the camps and women and children were much affected. Cases of avoidable mortality were reported. These all point to inadequate healthcare facilities in the camps, which are still poorly accessed. Another influence on the health conditions of the IDPs is the unhygienic environment. As a result, malaria, cholera, and meningitis were prevalent. Several issues were held accountable for obstructed access to available healthcare facilities in the camps including inefficiency of health workers, inadequate health workforce, poorly equipped clinics, corruption, unnecessary bureaucracy, and gender differences. IDPs who were referred to facilities outside the camps could not pay their health bills and were at the risk of death. This study concludes with the need to improve the governance structure and health resources in taking care of IDPs, so as to scale up access and also curb health inequalities which the IDPs currently face. We hope that implementing these solutions will guarantee the IDPs their rights to quality healthcare in line with the Universal Health Coverage. Finally, our study had a few limitations. First, was the utilization of only camp officials—which was because of denial of access to the IDPs given certain security concerns—at the time the study was conducted. Second, the camps we studied are all in the Northern part of Nigeria; there might be the need to undertake a similar study in the Southern part. Lastly, we emphasized physiological health experiences of the IDPs, but we barely mentioned their psychosocial health experiences. We suggest future studies to consider the latter.

Declaration of Interest Statement

The authors do not have any conflict of interest.

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